Alberta Health Services

Consent to Disclose Personal Information
Freedom of Information and Protection of Privacy (FOIP) Act

The individual or their authorized representative must complete this form before Alberta Health Services (AHS) may disclose the individual's personal information to someone else (unless Alberta's *Freedom of Information and Protection of Privacy (FOIP) Act* authorizes disclosure without consent).

Section A: Individual Information

Please note you are the individual who is the subject of the personal information to be disclosed.

Last Name	First Name

Section B: What personal information do you want disclosed?

Please provide details about the personal information you want disclosed, such as the name of the AHS location/facility that has the personal information and the time period of the records.

Section C: What individual/organization is the individual's personal information being disclosed to?

Name of Individual/Organization		Phone	
Address	City/Town	Province	Postal Code

Section D: Authorized Representative *(required when asking for personal information on behalf of another person)*

If you are signing on behalf of the individual named in section A, please choose one of the options below and provide a copy of supporting documents.

I, _____, am
(insert representative name)

- ☐ the **personal representative** of a deceased individual appointed by the individual's will or by the Court, administering the individual's estate.
- ☐ the **guardian** or **trustee** appointed for the individual under the *Adult Guardianship and Trusteeship Act* exercising my powers or duties as their guardian or trustee.
- ☐ the individual's **agent** named in an activated Personal Directive under the *Personal Directives Act* exercising my authority set out in the Personal Directive.
- ☐ the individual's **named attorney** in a Power of Attorney currently in effect exercising my powers and duties conferred by the Power of Attorney.
- ☐ the **parent** or **legally appointed guardian** of the individual who is under 18 years of age and who is not a mature minor in relation to their personal information.
- ☐ a **person with written authorization** from the individual to act on their behalf.

Section E: Consent for Disclosure

I authorize Alberta Health Services to disclose the personal information described above to the individual or organization(s) identified above. I understand why I have been asked to disclose my personal information and I am aware of the risks and benefits of consenting or refusing to consent. I understand I may revoke this consent in writing at any time.

Date consent is effective *(yyyy-Mon-dd)*	Expiry date *(yyyy-Mon-dd)(valid for 2 years if no date provided)*	
Name of person giving consent	Phone	Email
Signature	Date *(yyyy-Mon-dd)*	

The collection of your personal information on this form and the supporting documentation is legally authorized by section 33 (c) of the Freedom of Information and Protection of Privacy Act (Alberta). Your information will only be used and disclosed as necessary for responding to your request. If you have any questions about the collection of your personal information as provided on this form, please contact a Privacy Advisor by emailing privacy@ahs.ca, or send your questions in writing by prepaid mail addressed to the attention of Information & Privacy at Seventh Street Plaza 5th Floor North Tower 10030-107 Street Edmonton AB T5J 3E4.